**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
KINDRED HOSPITAL HOUSTON MEDICAL CENTER

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**
M4-13-1995-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
APRIL 8, 2013

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "…there is no basis for the denial of services as medical record documentation clearly supports medical necessity in that care or services could not have been provided in a less acute setting, thus granting retro-authorization for this claim is warranted."

**Amount in Dispute:** $41,357.08

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requestor sought preauthorization for admission to its Long Term Care Hospital (LTCH) on 3/26/12 (Attachment 1) Texas Mutual on 3/27/12 preauthorized fourteen days inpatient admission the requestor to be done between 3/27/12 through 4/10/12. (Attachment 2) The claimant remained in the LTCH beyond the authorized dates above from 4/11/12 through 5/9/12. Texas Mutual has no record of any requests for continued length of stay from the requestor as required by Rule 134.600(p)(1). The requestor has essentially admitted in its letter of 4.5.13 it failed to obtain preauthorization for the continued length of stay. In effect the requestor waived its right to payment. Now it seeks to circumvent that by an appeal to medical necessity. However, Texas Mutual did not deny reimbursement absent medical necessity but used a medical fee denial due to the requestor's failure to comply with Rule 134.600(p)(1). The requestor on some level certainly understood the need to preauthorize because it sought it on 3/26/12 and sought it also on 1/4/12, another date the requestor sought preauthorization for admission of the claimant to its LTCH (Attachment 3) No payment is due."

**Response Submitted by:** Texas Mutual Insurance Co.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 11, 2012 through May 9, 2012 | Long Term Care Hospital Services | $41,357.08 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Please note: TMI has no record of any preauthorization for dates after 4/10/12.
   - CAC-197-Precertification/authorization/notification absent.
   - 240-Preauthorization not obtained.

**Issues**

Does a preauthorization issue exist in this dispute? Is the requestor entitled to reimbursement?

**Findings**

28 Texas Administrative Code §134.600 (c)(1)(A) and (B), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:
(A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

28 Texas Administrative Code §134.600(p)(1) states "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay."

On March 27, 2012, the requestor obtained preauthorization approval for fourteen (14) inpatient long term acute care stay at Kindred Hospital starting March 27, 2012 through April 10, 2012. The hospital bill indicates that the claimant's inpatient stay was from March 27, 2012 through May 9, 2012; therefore, dates of service April 11, 2012 through May 9, 2012 required concurrent preauthorization approval.

28 Texas Administrative Code §134.600(q)(1) states "The health care requiring concurrent review for an extension for previously approved services includes: (1) inpatient length of stay." The requestor did not submit documentation to support concurrent preauthorization was obtained in accordance with 28 Texas Administrative Code §134.600(q)(1) for dates of service April 11, 2012 through May 9, 2012. Because a preauthorization issue exist reimbursement cannot be recommended for dates of service April 11, 2012 through May 9, 2012.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 04/23/2014<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.